5. Physician Services (Continued)

Medical Professional Services Affiliated with a State Operated University

Effective September 30, 2003, professional services provided by medical professional providers affiliated with a State Operated University shall be reimbursed based on the allowable costs of providing such services, as determined by the Department (or at a higher level if authorized by another provision of this State Plan). Eligible medical professionals shall be paid a base amount according to otherwise applicable provisions of this State Plan. An interim supplemental cost-based adjustment shall be paid on a monthly basis. The amount of the interim supplemental adjustment shall be determined prospectively before the start of the state fiscal year as follows, based on the most recent audited state fiscal year data available:

1. **Determine total costs for the medical professional providers affiliated with the State Operated University, including salaries, benefits, services, supplies, equipment, and allocated general and administrative expenses, physical plant expenses and library and educational support expenses.**
2. **From the amount determined in Step 1, deduct all non-allowable costs, including costs associated with research, grants, endowment spending, contracts, VA faculty costs, and house staff.**
3. **Determine the ratio of Medicaid charges to total charges for the medical professional providers affiliated with the State Operated University.**
4. **Multiply the amount determined in Step 2 by the ratio determined in Step 3.**
5. **Subtract the base amount of Medicaid reimbursement received by the medical professionals pursuant to other provisions of this State Plan from the amount determined in Step 4.**
6. **Divide the amount determined in Step 5 by 12. The result shall be the amount of the monthly interim supplemental adjustment for the upcoming fiscal year.**

After the end of the state fiscal year, an adjustment shall be made (upwards or downwards) to the total amount payable under this provision based on the actual costs incurred by the medical professionals affiliated with the State Operated University for the fiscal year.

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

6e. Medical Professional Services Affiliated with a State Operated University

Effective September 30, 2003, professional services provided by medical professional providers affiliated with a State Operated University shall be reimbursed based on the allowable costs of providing such services, as determined by the Department (or at a higher level if authorized by another provision of this State Plan). Eligible medical professionals shall be paid a base amount according to otherwise applicable provisions of this State Plan. An interim supplemental cost-based adjustment shall be paid on a monthly basis. The amount of the interim supplemental adjustment shall be determined prospectively before the start of the state fiscal year as follows, based on the most recent audited state fiscal year data available:

1. **Determine total costs for the medical professional providers affiliated with the State Operated University, including salaries, benefits, services, supplies, equipment, and allocated general and administrative expenses, physical plant expenses and library and educational support expenses.**
2. **From the amount determined in Step 1, deduct all non-allowable costs, including costs associated with research, grants, endowment spending, contracts, VA faculty costs, and house staff.**
3. **Determine the ratio of Medicaid charges to total charges for the medical professional providers affiliated with the State Operated University.**
4. **Multiply the amount determined in Step 2 by the ratio determined in Step 3.**
5. **Subtract the base amount of Medicaid reimbursement received by the medical professionals pursuant to other provisions of this State Plan from the amount determined in Step 4.**
6. **Divide the amount determined in Step 5 by 12. The result shall be the amount of the monthly interim supplemental adjustment for the upcoming fiscal year.**

After the end of the state fiscal year, an adjustment shall be made (upwards or downwards) to the total amount payable under this provision based on the actual costs incurred by the medical professionals affiliated with the State Operated University for the fiscal year.

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area; and

b. Home health aide services provided by a home health agency

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a. and b. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home

(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.l-A and Attachment 3.l-B, Item l2.c.7.

9. Clinic Services (Continued)

(5) End-Stage Renal Disease (ESRD) Facility Services

Reimbursement is made at the lower of: (a) the provider's actual charge for the service or (b) the allowable fee from the State's ESRD fee schedule based on reasonable charge.

The Medicaid maximum is based on the 50th percentile of the Arkansas Medicare facility rates in effect March 1, 1988. Rates will be reviewed annually.

After discussion with **CMS**, it was determined that the Arkansas Medicare 75th percentile is considered the norm for Arkansas Medicare reimbursement. Since the State reimburses at Arkansas Medicare's 50th percentile, the reimbursement rates will not exceed Arkansas Medicare on the aggregate.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

(6) Medical Professional Services Affiliated with a State Operated University

Effective September 30, 2003, professional services provided by medical professional providers affiliated with a State Operated University shall be reimbursed based on the allowable costs of providing such services, as determined by the Department (or at a higher level if authorized by another provision of this State Plan). Eligible medical professionals shall be paid a base amount according to otherwise applicable provisions of this State Plan. An interim supplemental cost-based adjustment shall be paid on a monthly basis. The amount of the interim supplemental adjustment shall be determined prospectively before the start of the state fiscal year as follows, based on the most recent audited state fiscal year data available:

1. Determine total costs for the medical professional providers affiliated with the State Operated University, including salaries, benefits, services, supplies, equipment, and allocated general and administrative expenses, physical plant expenses and library and educational support expenses.
2. From the amount determined in Step 1, deduct all non-allowable costs, including costs associated with research, grants, endowment spending, contracts, VA faculty costs, and house staff.
3. Determine the ratio of Medicaid charges to total charges for the medical professional providers affiliated with the State Operated University.
4. Multiply the amount determined in Step 2 by the ratio determined in Step 3.
5. Subtract the base amount of Medicaid reimbursement received by the medical professionals pursuant to other provisions of this State Plan from the amount determined in Step 4.
6. Divide the amount determined in Step 5 by 12. The result shall be the amount of the monthly interim supplemental adjustment for the upcoming fiscal year.

After the end of the state fiscal year, an adjustment shall be made (upwards or downwards) to the total amount payable under this provision based on the actual costs incurred by the medical professionals affiliated with the State Operated University for the fiscal year.

10. Dental Services

Refer to Attachment 4.19-B, Item 4.b.(18).